South Carolina Department of Health and Human Services

DISABILITY REPORT – Child Under Age 19

☐ **Initial** ☐ **Retro Only**

Instructions: This form is used to request a disability determination as an eligibility requirement for Medicaid. ***It is the responsibility of the Medicaid Eligibility Worker to ensure that each blank is completed.*** A copy of the completed form must be maintained in the case record.

Applicant _____ Social Security No. _____
(Please Print)

Applicant's Address _____

City _____ State _____ Zip Code _____ County _____

Date of Birth _____ Telephone(____) _____ Category of Application _____

If Deceased, Date of Death _____ Month _____ Day _____ Year Male *or* Female
(Circle One)

Application Date _____ Retro Month(s) Requested _____

Contact Person _____ Telephone(____) _____

Relationship to Applicant _____

Contact Person's Address _____
City, State Zip Code

Medicaid Eligibility Worker _____ Telephone(____) _____

Worker's Address _____
(Give Complete Mailing Address)

Worker's Supervisor _____ Telephone(____) _____

Date of Disability Onset or Last Continuing Disability Review _____

I. DISABILITY

a) When did the child become disabled? _____ Month _____ Day _____ Year

b) What is the child's disability? _____

c) Explain how the child's disability affects his or her ability to function. _____

d) Have you applied for Social Security Income (SSI) disability benefits? ☐ Yes ☐ No

If yes, date of application: _____

Was application made in SC? ☐ Yes ☐ No If no, what state? _____

If denied, have you asked the Social Security Administration (SSA) to reconsider your claim?
☐ Yes ☐ No

Did SSA refuse to reconsider your claim? ☐ Yes ☐ No

Did you request an appeal or a hearing? ☐ Yes ☐ No

e) Please give the name of anyone we may contact (other than the child's doctor or teacher), such as a neighbor, grandparent, etc., who knows about the child's condition.

Name of Contact _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone _____ Relationship to child _____

f) Please give the name of the child's regular pediatrician and his or her complete address and telephone number.

Name _____ Telephone (_____) _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next Appointment _____

II. MEDICAL INFORMATION ABOUT THE CHILD'S DISABILITY

NOTE: If you need additional space for medical sources, list their names, addresses and reasons for visits in the "Remarks" section on page five or attach a separate piece of paper.

a) List name, address and telephone number of the doctor who has the child's most recent medical records. *(We need a complete address to request medical records.)*

Name _____ Telephone (_____) _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Reason for visits _____

_____

b) Has the child been seen by any other doctors since the disability or injury began?
☐ Yes ☐ No If yes, complete the following. (We *need a complete address.)*

Name _____ Telephone (_____) _____

Street Address _____

City _____ State _____ Zip Code _____

Date first seen: _____ Date last seen: _____ Next appointment: _____

Reason for visits _____

_____

c) Has the child been hospitalized or received emergency room treatment for the illness or injury?
☐ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Hospital _____ Patient Number _____

Street Address _____

City _____ State _____ Zip Code _____

Was the child an in-patient (stayed at least overnight)? ☐ Yes ☐ No

Admission Dates: _____

Reason for Hospitalization or Emergency Room Treatment _____

_____

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d) Has the child received treatment from a hospital outpatient clinic or other type of clinic?
☐ Yes ☐ No If yes, complete the following. *(We need a complete address.)*

Name of Clinic _____ Patient Number _____

Street Address _____

City _____ State _____ Zip Code _____

Date(s) of Treatment: _____

Reason for Treatment _____

_____

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e) Has the child had any special diagnostic outpatient studies (x-rays, blood tests, EKG's, etc.) performed at a hospital or private laboratory/clinic? ☐ Yes ☐ No
If yes, complete the following. *(We need a complete address.)*

Type of Study/Test _____

Name of Hospital, Clinic or Laboratory _____

Street Address _____

City _____ State _____ Zip Code _____

When were these studies done? _____

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f) Is the child seen regularly or has the child ever been tested or evaluated by any of the following agencies? If available, please include copies of any medical, psychological, developmental information/assessments (including service plans) from these agencies.

1. S.C. Health Department Clinic ☐ Yes ☐ No
   Division of Children's Health ☐ Yes ☐ No
   Children's Rehabilitative Services (CRS) ☐ Yes ☐ No
   Women, Infant and Children's Program (WIC) ☐ Yes ☐ No
   Baby Net ☐ Yes ☐ No

2. Department of Disabilities and Special Needs (DDSN) ☐ Yes ☐ No

	County DDSN Board/Regional Center	☐ Yes	☐ No
3.	South Carolina Department of Mental Health	☐ Yes	☐ No
	Mental Health Center	☐ Yes	☐ No
4.	Continuum of Care for Emotionally Disturbed Children	☐ Yes	☐ No
5.	Speech and Hearing Center	☐ Yes	☐ No
6.	Other (i.e., physical, occupational therapy, etc.)	☐ Yes	☐ No

If yes, specify: _____

For each of the agencies at which the child has been seen, complete the following. If you have a copy of the child's service plan, please attach.

Name of Facility_____

Street Address_____

City_____State_____Zip Code_____

Date first seen:_____Date last seen:_____Next appointment:_____

Type of Treatment or Evaluation Received_____

Case Manager_____Telephone **(** **)** _____

Name of Facility_____

Street Address_____

City_____State_____Zip Code_____

Date first seen:_____Date last seen:_____Next appointment:_____

Type of Treatment or Evaluation Received_____

Case Manager_____Telephone **(** **)** _____

III. SCHOOL INFORMATION

a) Is the child currently attending school? ☐ Yes ☐ No If yes, complete the following.

Current Grade _____Teacher _____

Name of School_____

Street Address_____

City_____State_____Zip Code_____County_____

b) Is the child in a special education program? ☐ Yes ☐ No
If yes, explain the services provided (i.e., speech, learning disabled, etc.)_____

_____

Special Education Teacher's name:_____

Do you have a copy of the child's Individual Education Plan (IEP) report? ☐ Yes ☐ No
` If yes, please attach a copy.

c) Does the child attend any type of preschool, daycare or after school program?
☐ Yes ☐ No If yes, please complete the following.

Name of School _____

Street Address _____

City _____ State _____ Zip Code _____

IV. DAILY ACTIVITIES

Describe what the child does in a typical day. Include any participation in school, church or community activities.

_____

_____

_____

V. REMARKS

Use this section to answer any previous questions and to add additional information that you think will be helpful in making a decision in your child's disability claim.

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.

Print Name of Applicant/Representative _____

Applicant/Representative Signature _____ **Date** _____

Relationship _____